McAlear Eye Care

NEW PT

EXIS PT

Patient's Name_____ Date of Birth_____

Mail Address: _____City_____State_____Zip_____

Telephone: Home _____ Cell _____ □ OK to send text messages

Email: _____ Emergency Contact & Phone Number: _____

Name of Primary Care Physician: _____

If you are a NEW patient please fill out this box:

Race: ☐ African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Caucasian ☐ Hispanic
☐ Multiracial_____ ☐ Other_____

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Date of Last Eye Exam_____ Name of Previous Eye Doctor_____

Whom may we thank for referring you to our practice? _____

Do you currently: ☐ **Wear Glasses** ☐ **Wear Contacts** ☐ **Both**

Please note: A contact lens examination is more in depth than a typical routine eye exam. A comprehensive contact lens exam includes a thorough evaluation of your vision, the internal health of your eyes; your cornea where the lens sits, the underside of your lids as well as additional testing that requires more of the doctor's time and expertise. The fee for this service is either $50 or $75 depending on your RX and is collected every year as we have to check your eye health annually.

Please list any concerns you have that you would like to discuss with the doctor:

Please note: We encourage you to raise any eye health concerns with the doctor, however, please understand that these issues are likely outside the scope of a routine eye exam, and your visit may need to be billed to your medical insurance. In this case, medical insurance copays and deductibles apply.

Concern/Discussion Ex. Headaches	Date of Onset Ex. June 2015	Frequency (if applicable) Ex. 4 x per week	Severity Ex. Moderate
1.			
2.			
3.			

Do you have any allergic reactions to medications or other substances? ☐ **Yes** ☐ **No**
If yes, please list_____

Do you take medications? ☐ **Yes** ☐ **No** If yes, please list_____

_____

Do you smoke? ☐ **Yes Currently** ☐ **Never Smoked** ☐ **Former Smoker - how long since quitting**_____
Do you drink alcohol? ☐ **No** ☐ **Occasionally/Socially** ☐ **Regularly**

For Women: Are you, or could you be pregnant? ☐ **Yes** ☐ **No** ☐ **Maybe/Planning** ☐ **Nursing**

Have you or your blood relatives had any of the following conditions?

	YOURSELF	FAMILY		**YOURSELF**
Glaucoma	☐Yes ☐No	☐Yes ☐No	**Diabetes**	☐Yes ☐No
Blindness	☐Yes ☐No	☐Yes ☐No	**Rheumatoid Arthritis**	☐Yes ☐No
Crossed/Lazy Eyes	☐Yes ☐No	☐Yes ☐No	Thyroid disease	☐Yes ☐No
Color Deficiency	☐Yes ☐No	☐Yes ☐No	Stroke	☐Yes ☐No
Eye Surgery	☐Yes ☐No	☐Yes ☐No	High Blood Pressure	☐Yes ☐No
Retinal Detachment	☐Yes ☐No	☐Yes ☐No	Heart Disease	☐Yes ☐No
Macular Degeneration	☐Yes ☐No	☐Yes ☐No	Neurological (headaches, numbness)	☐Yes ☐No
Cancer	☐Yes ☐No	☐Yes ☐No	Gastrointestinal (stomach, intestines, liver)	☐Yes ☐No

Other condition(s) not listed above: _____

Please list any surgeries (what type & when) _____

Vision Care Plan Acknowledgement

Our role is to be your advocate and to help you to maximize your benefits. We want to make sure you receive everything you are entitled to and we want you to be happy and satisfied.

We also want to make sure you are aware of the following:

1) With few exceptions, vision care plans provide routine exams only, not medical eye care. Copayments are set by your insurance plan.
2) Your vision plan uses their lab to manufacture your eyewear and can take at least 2 weeks (sometimes longer) for them to send us your eyewear. We have **no control** over when your eyewear will be ready.
3) Your insurance company **does not provide refunds**, and any warranty is according to their terms.
4) Eyewear orders are submitted to your insurance company immediately once the order is finalized. **Changes cannot be made after submission**.
5) If you are unhappy with the eyewear your insurance company provides we will be your advocate and assist you, **BUT** your insurance company makes the final decision about how any concerns will be resolved.

HIPAA PRIVACY ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY NOTICE

_____ **(Initial here)**, I have been shown the Notice of Privacy Policy of this provider and have been offered a copy of such policy to keep for my records.

IF YOU ARE OVER THE AGE OF 18, WE CAN NOT DISCLOSE ANY MEDICAL INFORMATION TO YOUR FAMILY MEMBERS WITHOUT YOUR CONSENT. IF YOU WOULD LIKE US TO BE ABLE TO TALK TO A FAMILY MEMBER OR CAREGIVER (i.e Parent, spouse or adult child) PLEASE LIST THEM HERE. WE WILL NOT DISCUSS YOUR CONDITIONS OR HISTORY WITH ANY FAMILY MEMBERS NOT LISTED HERE.

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

By signing below, I understand and agree to the terms described herein and agree to accept responsibility for the payment of services. I have reviewed the office policies (10/12/17 revision) and acknowledge and agree to the stated policies. As a reminder: all copays and fees are due at time of service. I agree to pay all costs incurred by my failure to remit for services rendered, including fees charged by a collection agency. I grant my permission to you, or your assigns, to telephone me at home or other phone numbers listed to discuss financial matters related to this form. Furthermore, I authorize the release of any medical or other information necessary to process this claim and authorize the vision benefits otherwise payable to me to be paid directly to McAlear Eye Care.

Signature of Patient or Legal Guardian: _____ Date_____

Relationship to patient (if other than patient): _____

(For Office Use Only)

REASON FOR VISIT: Routine CL Medical CEE Medical PF REF Only CL: IN OUT

OPTOMAP: Elective Screening Medical DILATION DLY WAIVER

INSURANCE: Davis EyeMed VSP Medicaid/Other: _____ Medicare

BCBS/HP HMO or PPO Med Ins: _____ None/OOP